



March 6, 2020

Via Email: Jacey.cooper@dhcs.ca.gov

Attention: Jacey Cooper, State Medicaid Director and Chief Deputy Director of Health Care Programs

California Department of Health Care Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899

RE: Behavioral Health Medical Necessity Proposals

Dear Ms. Cooper,

The California Children's Trust (CCT) and the California Alliance of Child and Family Services (Alliance) are pleased to submit comments in response to the California Advancing and Innovating Medi-Cal (CalAIM) initiative led by the Department of Health Care Services (DHCS). The CCT represents a broad statewide coalition of stakeholders committed to addressing the children's behavioral health crisis in California. The Alliance is a statewide association of more than 145 nationally accredited, private nonprofit agencies dedicated to achieving progressively better outcomes for vulnerable children, youth and families in public human services systems.

Our comments in this letter focus on items discussed at the Behavioral Health workgroup meeting on February 26th concerning the Medical Necessity proposals.

The CCT and the Alliance support CalAIM's approach to modifying existing eligibility criteria for Medi-Cal outpatient and inpatient specialty mental health services in order to align with the EPSDT federal entitlement. We strongly support CalAIM's recognition that Medi-Cal eligibility criteria should be driven not just by diagnosis, but also by "level of impairment or a set of factors across the biopsychosocial continuum" (CalAIM Proposal, p. 75).

Science and best practices tell us that regarding behavioral health, especially children's behavioral health, **we must shift from a diagnosis-driven system to an approach that is**

responsive to the level of impairment and reflects an understanding of the impact of trauma and social determinants of health (SDOH) on long-term health and mental health outcomes.

Screening Tools

As CCT and the Alliance have commented in prior letters, we continue to feel strongly that additional work regarding identifying the best screening tool for children and youth for both mental health and substance use should occur prior to DHCS selecting a tool. The ease with which the state can determine a screening tool for adults in the mental health system is due primarily to a fairly clear delineation of the different adult populations that MCPs and MHPs serve. The intensity, duration and even location of service for adults is able to be tied to the service delivery system using the mild, moderate, and severe levels of need. This is similarly true, for the most part, for adults having substance use issues. There also seems to be strong consensus in the addictions community that the ASAM tool can provide a good screening to determine not only service delivery system, but perhaps also the level of care for clients.

For children and youth, there are multiple problems with this approach. To name a few:

- 1) The continued attempt to place children and youth into mild, moderate and severe categories associated with delivery system, when they should be receiving the full array of services regardless of the delivery system
- 2) The location of service is an important, if not critical component to the success of an intervention for a child and family. There is wide variety (based on contracts and MCP decisions) in where the range of services are provided. For the most part, MCPs provide only office-based services
- 3) The critical nature of continuity of care for children and youth, and moving between delivery systems can often have significant detrimental effects
- 4) The paucity of substance use services in both systems is well known, and again the state must find a way to uphold the federal EPSDT entitlement for these services in order to prevent more adults with chronic substance use issues

Given that DHCS has made clear that there will not be additional EPSDT services provided in the MCP system, CCT and the Alliance make the following recommendations:

- 1) Eliminate delivery system screening for children and youth and require a brief assessment be completed regardless of delivery system.***

The delivery system determination for youth should be based upon a brief in-person assessment, which could be conducted by a provider in either a county MHP or an MCP.

We agree with DHCS that the BQUIP is not an appropriate tool for determining which delivery system is appropriate for children and youth. We question, moreover, whether this important determination should be based upon information gathered during a ten-minute phone call. This decision depends in part on highly sensitive information, such as whether the youth has a history of traumatic experiences or significant mental health challenges, and many beneficiaries will be unwilling to reveal this type of information over the phone to a stranger. In light of these concerns, we recommend that DHCS instead base the delivery system determination on an in-person assessment.

We recommend that DHCS establish a workgroup of experts to create a brief assessment tool to guide providers in assessing the “scope and intensity” of the beneficiary's needs, as well as to ensure the beneficiary will be able to access medically necessary services. This tool could be based in part on questions drawn from the CANS and the PEARLS ACE’s screens. We recommend the assessment gather the following types of information:

- behavioral health symptoms and conditions;
- the youth’s need for coordination of services provided by other child-serving systems, such as education, child welfare and juvenile justice programs; and
- the ability of the client’s caregiver(s) to help the child access services, such as the caregiver(s) ability to drive the child to appointments. We believe this information is essential because, if the caregiver is unable to drive the youth to appointments, the child may not be able to access care unless they can receive services from a school-based or home-based provider, and nearly all of these staff are SMHS providers.

Finally, we recommend that DHCS enable families to have this brief assessment completed by a provider with either an MCP or an MHP. This would include contracted providers (community-based organizations) in these systems, particularly when a child at a school has been identified by a teacher as needing an assessment. This policy would minimize assessment wait times and strengthen CalAIM’s “No Wrong Door” approach.

2) *Foster Youth Should Have Automatic Access to SMHS Assessment and Services*

Of the two choices presented to the BH Workgroup on February 26, we believe that foster youth should receive a screening by the MHP, and once an assessment regarding the intensity, duration and location of service is determined, the MHP either provides/contracts for that service or refers to the MCP. Given that every foster child’s child welfare worker should be completing a CANS for them, for many of these youth, the initial CANS assessment will have been completed. We are concerned, however, that the option outlining that every foster child has a MHP case manager, could result in duplication of efforts between the Child Welfare case

worker and the MHP case manager. Given limited resources, and the opportunity to utilize Medi-Cal funds to serve more children and youth at risk of foster care, a careful review of roles and responsibilities between MHP and Child Welfare case managers should take place to determine if such a role is truly necessary.

Considering the trauma suffered by any youth who has been removed from their family home, we recommend that DHCS make every effort to minimize barriers to care for this population. Presumptive enrollment of foster youth in the MHP would further this goal by ensuring that each youth receives a comprehensive assessment conducted by a SMHS provider. Compared to MCP providers, SMHS providers should have a better understanding of the full range of SMHS available, and therefore they should be better equipped to connect the youth to all appropriate services. Additionally, continuity of care through the MHP should a child change foster care placements can be mandated. In addition, if a foster youth develops a mental health condition that requires more intensive services, they will be able to access that care more quickly if they already are enrolled in the county mental health plan.

We do acknowledge, on the other hand, that a small percentage of foster youth will not need the more intensive services offered through the county mental health plan. In addition, some youth may find that they prefer a particular MCP provider, especially if they already have established a relationship with that practitioner. For these reasons, we recommend that foster youth would be presumptively in the MHP behavioral health system, with an opt out to place them in the MCP delivery system.

Use of a “Lean” Assessment

CCT and the Alliance are very supportive of the use of a lean assessment tool similar to that presented at the BH Workgroup that provides enough of the information required to do a complete assessment of the client’s situation in order to develop a treatment plan, but without a level of detail that is unreasonable to achieve during an initial session, or at most, two sessions. We believe that an assessment process should apply to both adults and children/youth.

We would like to see integrated into the assessment the use of checkboxes or drop-down menus for items that do not require narratives, without impacting the quality and individualization of the assessment. Both CCT and the Alliance would like to see extensive capacity building regarding the expectations for the assessment process, treatment planning and ongoing documentation for county staff, providers, and auditors. It is critical that individuals in all of the behavioral health systems are “on the same page” in relation to the expectations. The potential unintended consequences of moving to a narrative based (albeit

“lean”) assessment is that there will be more room for interpretation by auditors regarding what is “enough” information to justify the need for services. Without clarity on the level of detail needed, it would be very easy for service providers to simply put as much information into an assessment as possible, resulting in unwieldy paperwork and more documentation time.

Certainly the change in medical necessity will aid in the need for substantial paperwork to justify a diagnosis on the front end of treatment. **However, this is a seismic culture shift in how our system currently operates and will need extensive training and capacity building at all levels.** We know that the capacity building involved in shifting culture with regard to the Continuum of Care Reform in foster care has been inadequate, resulting in years of having to react and respond rather than plan, train and provide technical assistance before problems arose that ultimately affect those being served by the system.

CCT and the Alliance believe strongly in the partnership between the service provider and the beneficiary, and the assessment and treatment planning process must engage the child, youth and their family (as age appropriate) in determining recommendations for treatment. Moving away from an audit-driven process will also allow for much more flexibility of how beneficiaries are engaged, allowing for a more culturally and linguistically responsive approach to service planning and delivery. The current system, unfortunately, has created a perverse approach to this by determining that a signature on a piece of paper is the best way to ensure that this partnership exists. This results in clinical staff chasing down signatures rather than focusing on relationship building. The “evidence” of client involvement should be a combination of the service provider’s acknowledgement and the progress made in the clinical process rather than the requirement for a written signature.

The most significant positive implication of chart review moving away from a financial function to a quality function will be that service providers will focus their time and attention on the needs of the beneficiary rather than on chart audits. Again, we cannot underscore how important training and capacity building will be here. The system has for so long been built around the fear and anxiety of audits, changing behavior at all levels will take time and attention. Understanding just how expectations for quality care will be determined and evaluated will be one important element to effective implementation. **The Alliance and CCT strongly recommend a robust process for building the capacity of the field, and involving stakeholders in the development and implementation of this process.**

Additional Comments Related to Medical Necessity and Documentation

1) Documentation Streamlining: Remove Requirement that Progress Notes Justify Time Spent

We strongly support documentation streamlining measures designed to eliminate administrative burdens that lack clinical value. We are pleased to see, for example, the proposed shift to a “lean standardized assessment” and “problem lists,” as well as the decision by DHCS to stop monitoring whether the treatment plan has been completed and signed by the beneficiary, and whether documentation shows that each intervention supports the treatment plan. We also applaud the shift away from recoupments for documentation issues that do not involve fraud, waste, or abuse.

We remain concerned, however, that providers may continue to be required to write extensively detailed narrative progress notes that add little clinical value. Currently, to avoid county audit recoupments, staff must write progress notes that justify every minute of time billed. As a result, an “audit worthy” progress note often appears more like a laundry list of actions taken and statements made, rather than a useful synthesis of therapeutic interventions and client progress throughout the session. To ensure that progress note requirements support CalAIM’s goal of documenting for clinical value -- rather than audit risk reduction -- **we urge DHCS to clarify that it will no longer monitor whether progress notes justify the amount of time spent providing a service.**

2) Remove Requirement that Licensed Practitioners of the Healing Arts Approve Progress Notes

DHCS has indicated it needs to better understand the benefits and costs of requiring that all progress notes be overseen by a Licensed Practitioner of the Healing Arts. Some counties currently require that all progress notes written by non-licensed providers be approved by an LPHA. We believe this requirement is unnecessarily burdensome. As discussed above, progress notes are often extremely detailed, especially in programs that require minute by minute documentation of each service provided. A blanket requirement that every progress note be reviewed by an LPHA creates an extensive drain on supervisors’ time, but often adds negligible clinical value. Some counties recognize this reality and do not impose this requirement. We recommend that DHCS issue guidance to all counties confirming that this rule is unduly burdensome and is not necessary to pass a state or federal audit.

Additional topic to address: Peer-Based Services

As DHCS considers options for further defining the scope of peers within the behavioral health system (for MCPs and MHPs), we encourage the Department to support legislation that is currently proposed this legislative session. Senate Bill 803 (Beall) would do the following:

- Establish peer certification in California
- Provide the structure needed to maximize federal match for peer services under Medi-Cal
- Define the range of responsibilities and practice guidelines for peer support specialists
- Specify training and continuing education requirements
- Determine clinical supervision requirements
- Establish a code of ethics

Prestigious organizations such as CMS, SAMHSA, and the Institute of Medicine among many others have identified peer delivered services offered through a certified peer specialist as being invaluable services. While increasing consumer wellness, the use of peer specialists decreases costs. Data shows a clear return on investment when peers are part of the mental health system. **We strongly believe that SB 803 is the best and most comprehensive vehicle to strengthen the peer role and make this a reality for California.**

Thank you to DHCS for the robust CalAIM stakeholder process and for your consideration of the recommendations contained in this letter on medical necessity. We have truly appreciated the collaboration and expertise of the DHCS staff at the CalAIM meetings.

With appreciation,



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